Northeastern Rehabilitation Associates, P.C.

Thank you for choosing Northeastern Rehabilitation Associates

-www.nerehab.com-

To ensure we are providing quality care, we need information from you and need to provide you with information about our practice policies. Our ***New Patient Brochure*** *is enclosed and it outlines our services and practice policies. Please review prior to your visit.*

Please complete the attached ***New Patient Packet*** *in its entirely* ***prior to arriving*** *for your appointment. This information is important for your physician to review with you during your initial visit and if not completed, it may delay your appointment time.*

Many of our patients experience acute and chronic pain. NERA Physicians will work with you to create an effective treatment plan, tailored just for you. Goals of a treatment plan often include reducing pain, maximizing your ability to perform functions of daily living and to help improve your quality of life. Patient Health Questionnaires are tools used to assist in creating your treatment plan. Please complete the enclosed, ***SOAPP-14*** *questionnaire and bring with you to your first visit. You may be asked to update this information annually or more often as your treatment plan changes over time.*

To provide you with secure electronic access to our physicians and staff, Northeastern Rehabilitation Associates utilizes a ***Patient Portal****. Instructions for access are included in this packet. You can request appointments, update your medical history, medications, allergies, and send a note to your provider. Your provider may send forms for you to complete as part of your treatment plan via the Portal as well.*

We encourage you to sign up for the Patient Portal before your first visit.

Revised 1/31/2019

Patient Information Sheet *(Please Print)*

Northeastern Rehabilitation ASSOCIATES, P.C.

Patient Name: _____
Last First Middle I

Date of Birth: _____ / _____ / _____ **Soc. Sec. # :** _____ / _____ / _____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_____

Home #: _____ **Cell #:** _____ **Work #:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact_____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

■ **Secondary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

PLEASE COMPLETE THIS SECTION IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT

Patient Name: _____

■ **Work Related Injuries**

Date of Injury: _____ / _____ / _____ **Claim #:** _____

Employer: _____ **County located in:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

Address where Injury Occurred- if different than address above:

City: _____ **State:** _____ **Zip:** _____

Job Title: _____ **Usual Job Duties:** _____

■ **Auto Accident**

Date of Injury: _____ / _____ / _____ **Claim #:** _____

State where Injury Occurred: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

■ **Attorney Information - if Applicable**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

PATIENT PAIN HISTORY:

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

1. Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous
2. What is your main complaint?_____
   _____
   _____
3. Is this the result of a Work Injury? ☐ No ☐ Yes **If yes**, date of injury: _____/_____/_____
   Describe this incident: _____
   _____
   _____
4. Is this the result of a Motor Vehicle Accident? ☐No ☐ Yes **If yes**, date of accident: _____/____/_____
   Describe this incident: ☐ Head-On ☐ Rear-Ended ☐ T-Boned ☐ Other_____
   _____

☐ Driver ☐ Passenger Front Seat ☐ Passenger Back Seat	☐ Loss of consciousness ☐ Airbags deployed ☐ Seatbelt	☐ Ambulance: ☐ C-Collar ☐ Backboard Name of ER: _____

5. If you answered NO to questions 3 and 4, please describe when and how your illness or injury occurred:
   _____
   _____
6. Have you had anything similar before? ☐ No ☐ Yes **If yes,** please explain:
   _____
   _____
7. Prior to this episode, were you completely symptom free? ☐Yes ☐ No **If no**, please explain:
   _____
   _____
8. What doctors have you seen for this problem?_____
   _____
9. TESTING
   Which of the following tests have been done for your condition?
   ☐ X-ray* Date:_____/_____/_____ Facility _____
   ☐ MRI* Date:_____/_____/_____ Facility _____
   ☐ Cat Scan* Date:_____/_____/_____ Facility _____
   ☐ Bone Scan* Date:_____/_____/_____ Facility _____
   ☐ EMG Date:_____/_____/_____ Facility _____
   ☐ Other: _____ Date:____/_____/_____ Facility _____

*** Please bring any/all X-rays, MRIs, and Medical Records that may pertain to your current problem/injury.**

Patient Name: _____

10. Please review the pain scale below. Indicate by answering **0-10** which best describes your pain level:
a. Current pain level:_____ **b.** Past 30 days, pain at its best:_____ **c**. Past 30 days, pain at its worst: _____

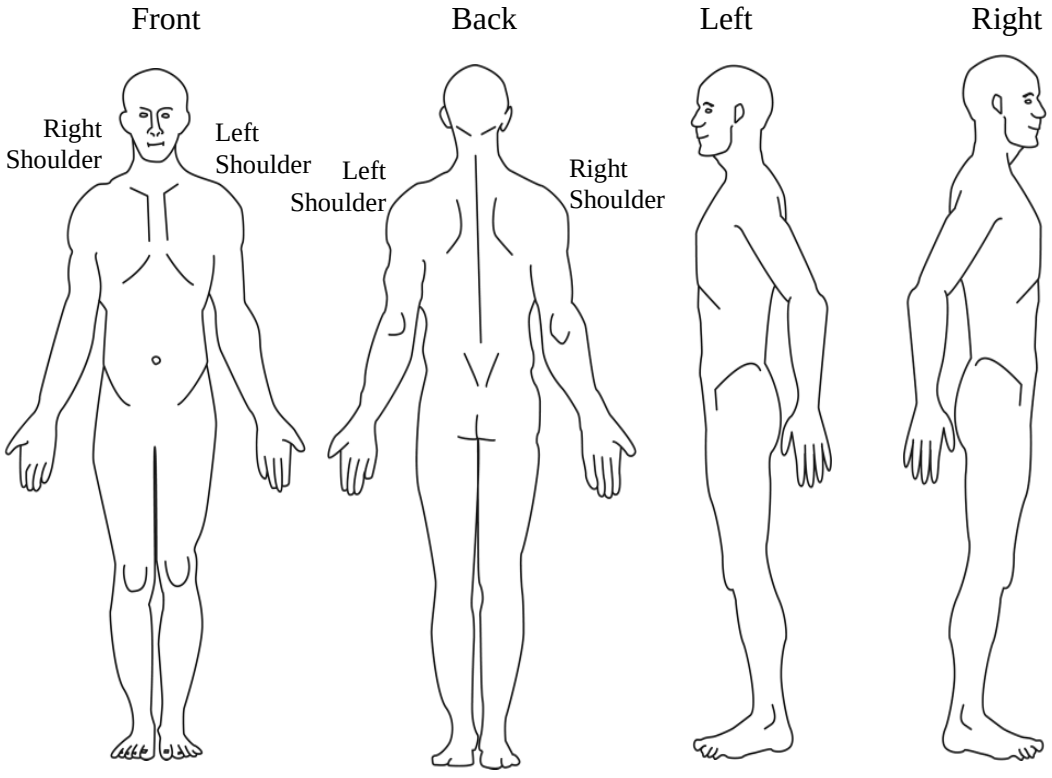
0	**No Pain**	I have no pain
1	**Minimal**	My pain is hardly noticeable
2	**Mild**	I have a low level of pain, I am aware of my pain only when I pay attention to it
3	**Uncomfortable**	My pain bothers me but I can ignore it most of the time
4	**Moderate**	I am constantly aware of my pain but I can continue with most of my activities
5	**Distracting**	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
6	**Distressing**	I think about my pain all of the time. I give up many activities because of my pain.
7	**Unmanageable**	I am in pain all the time. It keeps me from doing most activities
8	**Intense**	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
9	**Severe**	My pain is all that I can think about. I can barely talk or move because of the pain.
10	**Unable to Move**	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.

11. How frequent is your pain? ☐ Constant ☐Intermittent Explain_____
12. How long does your pain last? ☐ Less than 1 hour ☐ Less than 1 day ☐All day ☐All night
13. Is your pain getting: ☐ Better ☐ Worse ☐ Not changing

	Worsens Pain	**Relieves Pain**	**No Effect on Pain**		**Worsens Pain**	**Relieves Pain**	**No Effect on Pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on your back			
Bending to the side				Lying on your stomach			

USE THE FOLLOWING SYMBOLS TO INDICATE ON THE DRAWING EXACTLY WHERE YOUR PAIN IS <u>AT THE PRESENT TIME</u>.

Burning (X) Numbness (O) Pins/Needles (=) Stabbing (/) Ache (^) Throb (V **)**



Patient Name: _____

1. Have you had any Physical Therapy in the past 2 years? ☐ No ☐ Yes
   If yes, please indicate the following:

   a. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____
   b. Body Part Treated: _____ Facility:_____
   When (Month/Year): _____ How Long: _____

2. Please check next to any other treatments you have had for your **present** injury:

   ☐ Ice/Heat: Helpful? Yes ☐ No ☐
   ☐ Anti-inflammatory Medications (NSAIDs) including over the counter Advil, Aleve, etc.
   When? _____ / How Long?_____ Helpful? Yes ☐ No ☐

   ☐ TENS/ E Stim: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Traction: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Exercises: Helpful? Yes ☐ No ☐
   ☐ Acupuncture: Helpful? Yes ☐ No ☐
   ☐ Massage: Helpful? Yes ☐ No ☐
   ☐ Chiropractic: Helpful? Yes ☐ No ☐
   ☐ Injections: Helpful? Yes ☐ No ☐ What type of injection?_____
   When was your last injection? _____
   ☐ Bracing: Helpful? Yes ☐ No ☐
   ☐ Psychological Treatment: Helpful? Yes ☐ No ☐

3. With respect to your pain, how are you feeling now compared to before you received treatment?

   ☐ Very Much Worse ☐ Much Worse ☐ Minimally Worse ☐ No Change
   ☐ Minimally Improved ☐ Much Improved ☐ Very Improved

PAST MEDICAL HISTORY:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse	☐ Cholesterol	☐ Hepatitis	☐ Stroke/ TIA
☐ Arthritis (Osteoarthritis)	☐ Diabetes	☐ HIV/AIDS	☐ Thyroid
☐ Arthritis (Rheumatoid)	☐ Fibromyalgia	☐ Hypertension	☐ Anxiety
☐ Asthma	☐ GERD (Reflux)	☐ Kidney Disease	☐ Depression
☐ Cancer	☐ Heart Disease	☐ Liver Disease	
Type: _____	☐ Drug Abuse ☐ Prescription drugs ☐ Street drugs		

☐ Other: _____

☐ Past Work Injury – Date: _____ ☐ Past Motor Vehicle Accident – Date: _____

PLEASE LIST SURGERIES YOU HAVE HAD: **DATE:**

_____ _____
_____ _____
_____ _____

Patient Name: _____

FAMILY HISTORY: Please check any diseases/disorders that run in your family. **Do not include yourself**.

	Relative		**Relative**		**Relative**
☐ Heart disease	_____	☐ Arthritis	_____	☐ Hypertension	_____
☐ Alcohol Abuse	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Cancer	_____	☐ Other	_____		

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

EMPLOYMENT STATUS:

1. Job Title/Occupation: _____
2. Briefly describe your job duties: _____
3. Are you currently under work restrictions ☐ No ☐ Yes **If Yes,** what are your restrictions?
   _____
4. Please check current work status:
   ☐ Working Full Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Part Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Light Duty: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Off Duty Due to Injury: Date last worked: _____
   ☐ Retired/Not Working

ACTIVITIES OF DAILY LIVING: Please check the level you are presently able to complete the following activities:

	Independent	**Need some Assistance**	**Unable**		**Independent**	**Need some Assistance**	**Unable**
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean your house	☐	☐	☐
Bathe	☐	☐	☐	Care for your family	☐	☐	☐
Drive	☐	☐	☐				

1. Please list up to four things in your life that you can't do or have difficulty with because of your pain and which most dearly you want restored? These should be simple, realistic daily life improvements that other people can see most of the time.
   _____ _____
   _____ _____
2. Are there other limitations due to current condition?_____
3. At one time, how long can you: Sit _____ Stand_____ Walk_____
4. Do you use any of the following? ☐ Straight cane ☐ Quad cane ☐ Walker ☐ Wheelchair
   Prior to your injury/illness was your ability to do things at all limited? ☐No ☐Yes
   If yes, please explain: _____
5. Are there stairs to enter/or in your home? ☐ No ☐ Yes How many? ____ Is there a rail? ☐ Yes ☐ No

Patient Name:_____

Review of Systems

Do you have problems with any of the following? Please check all that apply.

General
☐Fatigue
☐Weakness
☐Trouble sleeping

Skin
☐Rashes
☐Dryness
☐Color changes
☐Hair/nail changes

Head
☐Headache
☐Head Injury

Eyes/Ears/Nose/Throat
☐Blurry or double vision
☐Eye pain
☐Blindness
☐Ear pain
☐Ringing in ears
☐Deafness
☐Nose bleeds
☐Dry mouth
☐Sore throat/hoarseness
☐Non-healing sores

Neck
☐Stiffness
☐Swollen glands
☐Pain

Cardiac
☐Palpitations
☐Chest discomfort at rest
☐Chest discomfort with activity

Respiratory
☐Wheezing
☐Shortness of breath with normal activity
☐Shortness of breath with exertion
☐Cough- wet, dry or productive
☐Coughing up blood

Circulation
☐Discoloration of feet/legs
☐Sores/ulcers on feet/legs
☐Swelling of ankles/legs
☐Calf pain with walking
☐Leg Cramps
☐Varicose veins

Gastrointestinal
☐Difficulty swallowing
☐Heartburn
☐Unexplained nausea/vomiting
☐Change in bowel habits
☐Constipation
☐Diarrhea
☐Blood in stool
☐Loss of bowel control
☐Abdominal pain

Genitourinary
☐Frequent urination
☐Painful urination
☐Loss of bladder control

Musculoskeletal
☐Muscle or joint pain
☐Stiffness
☐Back pain
☐Redness of joints
☐Swelling of joints
☐Trauma

Nervous System
☐Dizziness
☐Fainting
☐Seizures
☐Numbness/Tingling

Metabolism/Endocrine
☐Heat or cold intolerance
☐Excessive sweating
☐Increased thirst
☐Change in appetite
☐Recent unexplained weight changes

Hematology
☐Unexplained fevers
☐Ease of bruising
☐Ease of bleeding

Psychiatric
☐Nervousness
☐Memory loss
☐Stress
☐Bipolar Disorder
☐Other psychological diagnosis _____

Women Only
☐Currently pregnant
☐Breastfeeding
☐Date of last menstrual period
____/____/_____

Reviewed By:

_____

Date: _____/_____/_____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **ALL** medications taken on a daily basis, including **vitamins, herbals and over-the-counter medications**. Please list all **medication allergies.**
Please list pharmacy name and telephone number.

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed**:** _____

MEDICATION ALLERGIES:

_____

_____

Pharmacy Name _____ **Phone Number**_____

Northeastern Rehabilitation ASSOCIATES, P.C.

Screener and Opioid Assessment for Patients with Pain- SOAPP V1- 14Q

As part of your treatment plan with your Northeastern Rehabilitation Associates (NERA) physician, you may receive a prescription for a controlled substance medication. In addition to medication agreements and random drug screen protocols, NERA requires a medication screening form to be completed by all patients receiving these medications. **Your health insurance may also require a pre authorization of this medication before it can be filled by your pharmacy. The pre authorization process also requires the completion of this form.**

Name: _____ Date of Birth: _____ Date: _____

Please Print

The following are some questions given to all patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Please answer the questions below using the following scale: (Circle answer)

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	**0 1 2 3 4**
2.	How often do you smoke a cigarette within an hour after you wake up?	**0 1 2 3 4**
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	**0 1 2 3 4**
4.	How often have any of your close friends suggested that you have a drug or alcohol problem?	**0 1 2 3 4**
5.	How often is there tension in the home?	**0 1 2 3 4**
6.	How often have you attended an AA or NA meeting?	**0 1 2 3 4**
7.	How often have you taken medication other than the way it was prescribed?	**0 1 2 3 4**
8.	How often have you been treated for an alcohol or drug problem?	**0 1 2 3 4**
9.	How often have your medications been lost or stolen?	**0 1 2 3 4**
10.	How often have others expressed concern over your use of medication?	**0 1 2 3 4**
11.	How often have you felt a craving for medication?	**0 1 2 3 4**
12.	How often have you been asked to give a urine screen for substance abuse?	**0 1 2 3 4**
13.	How often have you used illegal drugs (example marijuana, cocaine, etc) in the past five years?	**0 1 2 3 4**
14.	How often, in your lifetime, have you had legal problems or been arrested?	**0 1 2 3 4**

Please include any additional information you wish about the above answers. Thank you.

NERA Medication Agreement/Refill Policy

Your treatment plan with NERA may include diagnostic and/ or therapeutic interventions, behavioral medicine, alternative therapies, physical therapy and use of prescription medications. Medications can have serious side effects if they are not managed properly. Your health and safety are very important to us. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship. You will receive information from your NERA physician regarding the risks and potential benefits of these medications and you should address any concerns regarding your medication regimen with your NERA physician.

Please read each statement and sign below. If you have any questions regarding this information or practice policy regarding the prescribing of controlled substances, please request clarification from your NERA physician. If you would like a copy of this Agreement for your records, please ask the staff to provide you with a copy during your visit.

You acknowledge that you:

1. Understand the main goal is to improve your ability to function /work and to reduce pain. You agree to comply with the treatment plan as prescribed by your NERA physician. In addition to utilizing pain medications, other medical treatments, following better health habits such as exercise, weight control and avoiding the use of nicotine and alcohol, may be part of your treatment plan. You understand that it may not be possible to completely eliminate all of your pain.

2. Understand that your medication regimen may be continued for a definitive time period as determined by your NERA physician. Your treatment plan will be reviewed periodically. If there is no significant evidence of improvement or progress being made to improve your functioning or quality of life, the regimen may be tapered or possibly discontinued and your care referred back to your primary care physician.

3. Understand you must inform your NERA provider of **all** medications you are taking, including over-the-counter, herbals, and vitamins, as controlled substances can interact with other medications.

4. Understand that you must notify your NERA physician if you have a history of alcohol and/or drug misuse/addiction, as treatment with controlled substances may increase the possibility of relapse.

5. Understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Possible complications include but are not limited to: constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration and reduced sexual function. You may develop a tolerance, and become physically dependent on the medication. You must notify your NERA physician if you experience any adverse effects with your prescribed medications.

6. Understand that opioid medications can cause physical dependence within a few weeks of taking these medicines. If you suddenly stop or decrease the medication, you could experience withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24- 48 hour of the last dose. Do not stop these medications without consulting your NERA physician.

7. Understand that the use of alcohol while taking controlled substances is contraindicated.

8. Agree to take the medications only and **exactly** as prescribed by your NERA physician.

9. (Female patients only) Understand that if you plan to get pregnant or believe that you have become pregnant while taking these medications, you will immediately call your Obstetric and NERA physicians to inform them. Understand that many medications could harm the fetus or cause birth defects.

10. Understand that you must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, making it unsafe to drive or operate heavy machinery. If there is any question of your ability to safely perform these activities, you will not attempt to perform the activity until the side effects have had time to resolve.

11. Agree to use only <u>one</u> pharmacy for your pain-related medications. In the event that circumstances require the use of another pharmacy, you will notify NERA of this immediately and provide all pertinent contact information.

12. Understand that NERA does not replace lost or stolen prescriptions or medications or those destroyed by fire, flood, etc. The safekeeping of your medication and prescriptions is your responsibility. This includes keeping medications out of reach of children. You will not share, sell, exchange or otherwise permit others to have access to these medications for any reason.

13. Agree that you will not seek or accept any pain medications other than those prescribed by my NERA physician. This includes prescriptions for pain medications from other physicians, medication borrowed or accepted from family or friends and any illicit or street drugs. If you are in an emergent situation, have surgery, a dental procedure, etc., and are given a controlled substance by another physician, you must notify your NERA physician as soon as possible. You consent to the disclosure of all personal health information related to this matter.

14. Agree that you will not use any illegal substance, (cocaine, heroin, marijuana, etc) while being treated with controlled substances. Using illegal substances will result in a change to your treatment plan, including the safe discontinuation of controlled substances when applicable or may result in the termination of the doctor/patient relationship. * If you are being prescribed *medical* marijuana, you must provide your NERA physician with verification before any controlled substances will be prescribed. Understand that medical marijuana is only legal at the state level and not at the federal level. Physician DEA licenses are registered at the federal level and may choose NOT to prescribe opiates to patients with positive marijuana screens despite PA law.

15. Agree to keep all scheduled appointments. Most patients taking controlled substances will need to be seen at least every one to three months. You understand that no medication prescriptions/refills will be given for canceled or no-show appointments. You understand that if you are 15 minutes late for an appointment time, you will be rescheduled for another appointment and no prescriptions/refills will be given. Scheduled appointments are required for all office visits. NERA physicians do not see “walk-in” patients.

16. Understand that each prescription is for a specific number of pills, designed to last a certain amount of time.
    - **Refills requests must be made at least two business days before your medication runs out**. **Requests made after this time frame will not be expedited.**
    - Early refills will not be given.
    - It is not our practice to make changes to your prescriptions by telephone.
    - New prescriptions, changes to prescriptions or medication refills will not be addressed after office hours, on weekends, or on holidays.
    - If you are experiencing concerns with your medications, you will be scheduled for an office appointment.
    - Medical Assistants are assisting the providers during the day and may not be able to speak with you directly at the time of your call. Please leave detailed information and you will receive a call back within 48 hours. If you are experiencing an emergency, please call 911 or go to an Emergency Room.
    - Please review *Medication Refill Policy* posted in all office locations for further details.

17. Understand that your NERA Provider is required to check your prescription history via the state database, *PA Aware,* every time you are prescribed a controlled substance and with medication refills.

18. Understand that you may be asked to bring any or all of your prescribed medicines to the office at a random time or at your office appointment, for a prescription compliance check (Pill Count). Understand that failure to comply with or discrepancy with pill counts may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

19. Understand that you will undergo random urine drug screens as long as your treatment plan utilizes controlled substances. You accept responsibility for the cost of the urine drug test in the event that your healthcare coverage will not cover the cost of this test. If the results of the urine drug screen do not reflect medicine prescribed by your physician, or you test positive for illegal substances, you understand this may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

20. Understand that altering a prescription in ***any*** way is against the law. Report of forged, falsified, or altered prescriptions will result in your immediate discharge from NERA. NERA cooperates fully with law enforcement agencies in regards to infractions involving prescription medications. Understand that if the responsible, legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

21. Understand that inappropriate, abusive behavior or harassment of any NERA staff member will not be tolerated.

22. Understand that NERA physicians may discontinue any prescriptions, and discharge you from the practice if any of the following occurs:
    - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
    - You fail to keep follow- up appointments,
    - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
    - You do not cooperate with requested Pill Counts or Urine Drug screens, or there is any discrepancy with results of Pill Counts and/or Urine Drug Screens.
    - You are released from the practice for any reason,
    - Any aggressive behavior toward NERA staff or physicians,

- Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your NERA physician.

By signing this document you acknowledge that:

- You have thoroughly read, understand and accept all the above statements.
- You have received and understand the NERA Prescription Refill Policy.
- You agree to adhere to the terms of this Medication Agreement and the NERA Prescription Refill Policy,knowing that failure to do so may result in termination of treatment with all NERA providers.
- This agreement is in effect for the duration of your treatment.
- Your NERA physician may provide a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.

Patient Signature _____ Date _____/_____/_____

Patient Name _____ Date of Birth _____/_____/_____
(Please Print)

Pharmacy Name: _____ **Phone#** _____ / _____ / _____

If you change your pharmacy for any reason, you agree to notify this office at the time you receive a prescription.

Reviewed by Physician/Staff Signature _____ Date____/____/____

6/04,/7/05,7/10,9/17

MEDICATION REFILL POLICY

****Refills requests must be made at least two business days before your medication is due. Requests made after this time will not be expedited. ****

When using your NERA Patient Portal or leaving a message in our Prescription Refill Voice Mail system, please leave your name, date of birth, pharmacy information and phone number where you may be reached.
Please do not leave repeat messages as this will delay response time.

- Refill requests will be addressed 9:00 AM- 4:00 PM, Monday through Friday. **Requests made after 4:00 PM will not be addressed until the next business day**

- Please check with your pharmacy for completed refill requests. We will only call you if there is a question regarding your refill. If you are experiencing an emergency, please call 911 or go to an Emergency Room.

- Early refills will not be given.

- It is not our practice to make changes to your prescriptions by telephone. You may be scheduled for an office visit to address medication concerns or changes.

- New prescriptions, changes to prescriptions or medication refills will not be addressed after office hours, on weekends, or on holidays.

- We do not accept walk-ins for refill requests.

- Lost or stolen prescriptions/medications will not be replaced.

- No refills will be given for canceled or no show appointments.

Please refer to your Medication Agreement for more information regarding Prescription Refills.